Methods and Standards for
Establishing Payment Rates: Other Types of Care

Advanced Nurse Practitioners

Payment is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. Laboratory services are reimbursed at the lesser of billed charges or the Medicare fee schedule. State developed fee schedule rates are the same for both public and private providers. Except as otherwise noted in the plan, state developed fees schedule rates are the same for both governmental and private providers. The fee schedule and its effective date are published at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

The fee schedule was last updated, to be effective for services on or after 7/1/2016.

Ambulatory Surgical Clinic Services

Payment is made to ambulatory (outpatient) surgical clinics on a prospectively determined rate. Payment covers all operative functions attendant to medically necessary surgery performed at the clinic by a private physician or dentist, including admitting and laboratory tests, patient history and examination, operating room staffing and attendants, recovery room care, and discharge. It includes all supplies related to the surgical care of the beneficiary while in the clinic. The payment excludes the physician, radiologist, and anesthesiologist fee. State developed fee schedule rates are the same for both public and private providers and the fee schedule is published at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

The fee schedule was last updated, to be effective for services on or after 7/1/2016.

Behavior Rehabilitation Services

Payment for Behavior Rehabilitation Services is a fee-for-service basis, with one day being the unit of service. Rates are based upon a periodic rate study using a prospective staffing based rate model that uses data gathered by the State Department of Labor reporting the prevailing wages in the State of Alaska. Specific position classifications were selected to reflect the comparable staffing requirements needed to provide quality rehabilitative services to the identified population. A factor is used to compensate for employee benefits and facility operating costs and supplies. Board and room are not included in the Behavioral Rehabilitative Service rate paid to the provider. These rates are periodically adjusted based on appropriate cost-of-living adjustments and other market indicators and program standards. Rates and rate methodology are found in Residential Behavioral Health Service handbook 2013 at
http://dhss.alaska.gov/dbh/Documents/TreatmentRecovery/RBRS%20Documents/BRS%20Handbook%2010-28-13.pdf

Certified Nurse Anesthetist Payment is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, or the provider's lowest charge. Payment rates are set using the Medicare Physician RBRVS payment rates and Alaska's state-specific conversion factor and inflation adjustments. The Medicare Physician RBRVS payment rates are published in the federal register as described under the Physician reimbursement section of this attachment (4.19B). Alaska's state-specific conversion factor and inflation adjustments are published in the Alaska Administrative Code. Changes to the Medicaid rates will only occur when Medicare updates the RBRVS payment rates each year and the department incorporates those changes with its Alaska-specific conversion factor and inflation adjustments the following July 1.

Chiropractic Services

Payment for manual manipulation to correct subluxation of the spine and x-rays is made at the lesser of billed charges, the Resource Based Relative Value Scale methodology used for physicians, or the provider's lowest charge. State developed fee schedule rates are the same for both public and private providers. The fee schedule and its effective dates are published at
http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

The fee schedule was last updated, to be effective for services on or after 7/1/2016.

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Community Health Aides - Payment for the services of community health aides III and IV or a community health practitioner certified by the state is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology, the provider's lowest charge, or the state maximum allowable for the procedures that do not have an RVU. For EPSDT screening services paid at 100 percent of the Resource Based Relative Value Scale methodology used for physicians. Payment rates are set using the Medicare Physician RBRVS payment rates and Alaska's state-specific conversion factor and inflation adjustments. The Medicare Physician RBRVS payment rates are published in the federal register as described under the Physician reimbursement section of this attachment (4.19B). Alaska's state-specific conversion factor and inflation adjustments are published in the Alaska Administrative Code. Changes to the Medicaid rates will only occur when Medicare updates the RBRVS payment rates each year and the department incorporates those changes with its Alaska-specific conversion factor and inflation adjustments the following July 1.

Dental Services

Payment is made at the lesser of billed charges, the Resource Based Relative Value Scale methodology used for physicians, or the provider's lowest charge. State developed fee schedule rates are the same for both public and private providers. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. The fee schedule and is effective dates are published at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

The fee schedule was last updated, to be effective for services on or after 7/1/2016.

Direct Entry Midwife Services

Payment is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, or the provider's lowest charge, State developed fee schedule rates are the same for both public and private providers. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. The fee schedule and its effective dates are published at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

The fee schedule was last updated to be effective for services on or after 7/1/2016.

EPSDT Screening Services

Payment is made at the lesser of billed charges, the Resource Based Relative Value Scale methodology for physicians or the provider's lowest charge. State developed fee schedule rates are the same for both public and private providers, except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. The fee schedule and its effective dates are published at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

The fee schedule was last updated to be effective for services on or after 7/1/2016.

Freestanding Birthing Center Services

Facility rates for freestanding birthing centers are based on 75 percent of the weighted average of the Medicaid hospital inpatient rates paid to the general acute care hospitals in Anchorage, Fairbanks, Juneau, Palmer, and Soldotna with a one day length of stay designated by a primary diagnosis code of 080 as described in the *International Classification of Diseases – 10th Revision, Clinical Modification* (ICD-10-CM, adopted by reference in 7 AAC 160.900; this amount is calculated each state fiscal year using the units of services from the most recent 12 month period starting at the beginning of the state fiscal year's fourth quarter and for which timely filing has already passed and the Medicaid hospital inpatient rates for each facility that are in effect at the start of the fourth quarter of the state fiscal year preceding the July 1 effective date.

EPSDT Continuing Care Provider Services

Continuing care providers, who have entered into an agreement with the Division of Medical Assistance in accordance with Section 3.1 (a)(9) of this Plan, will be reimbursed an amount equal to the costs associated with implementing the provisions of such an agreement.

Methods and Standards for
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Dental Services for Recipients age 21or older:
Payment is made at the lesser of billed charges, the Medicare Resource Based Relative Value Scale Methodology used for physicians **in those instances where Medicare sets an RVU for the billed dental service**, the provider's lowest charge, or the statewide fee schedule up to an annual limit of $1150 per Medicaid recipient age 21or older.

Except as otherwise noted in the plan, state developed rates are the same for both public and private providers of dental services. The agency's rates for dental services were updated on 07/01/2011 and are effective for services rendered on or after that date. The fee schedule and any annual/periodic adjustments to the fee schedule and its effective dates are published at http://medicaidalaska.com/providers/FeeSchedule.asp. This fee schedule includes dental procedures whose payments are limited by the physician payment amount for dental procedures.

Dentures
For recipients age 21 and older, dentures and the authorized services to prepare for them, are paid up to an annual limit of $1150 per recipient. When upper and lower dentures are necessary and the annual limit is not adequate to cover the cost of the dental claim, twice the annual limit may be authorized by the Department. When authorizing twice the annual limit for dentures, the maximum amount authorized is the remaining amount from the current fiscal year and the entire amount allotted for the succeeding fiscal year. The recipient is not allowed a new or additional annual limit for the succeeding year beyond that already paid for the dentures.

Except as otherwise noted in the plan, state developed rates are the same for both public and private providers of dentures. The agency's rates for dentures were updated on 07/01/2011 and are effective for services rendered on or after that date. The fee schedule and any annual/periodic adjustments to the fee schedule and its effective dates are included in the fee schedule for dental services published at http://medicaidalaska.com/providers/FeeSchedule.asp.

Methods and Standards for Establishing Payment Rates: Other Types of Care

Family Planning Services and Supplies

Payment is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures without an established RVU. Laboratory services are reimbursed at the lesser of billed charges or the Medicare fee schedule.

Federally Qualified Health Center Services

Payment for Federally Qualified Health Center Services conforms to section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000.

Prospective Payment System

All Federally Qualified Health Centers (FQHCs) are reimbursed on a prospective payment system beginning with Fiscal Year 2001 with respect to services furnished on or after January 1, 2001 and each succeeding year.

Payment rates will be set prospectively using the total of the center's reasonable costs for the center's fiscal years 1999 and 2000.These costs are divided by the average number of visits for the two-year period to arrive at a cost per visit. The cost per visit is adjusted to take into account any increase or decrease on the scope of services. The cost per visit is the prospective rate for calendar year 2001. Beginning in FY 2002, and for each center fiscal year thereafter, each center will be paid the amount (on a per visit basis) equal to the amount paid in the previous center fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the center. The center must supply documentation to justify scope of service adjustments. For state fiscal years 2016 and 2017, each center will be paid the amount (on a per visit basis) equal to the amount paid in the previous center fiscal year with no increase by the percentage increase in the Medicare Economic Index (MEI) for primary care services, but adjusted to take into account any increase (or decrease) in the scope of services furnished by the center.

For newly qualified FQHCs after State fiscal year 2000, initial payments are established by either reference to payments to other centers in the same or adjacent areas with similar caseload, or in the absence of other centers, by cost reporting methods. After the initial year, payment is set using the MEI methods used for other centers, and adjustments for increases or decreases on the scope of service furnished by the Center during that fiscal year. For state fiscal year 2016 and 2017, after the initial year for a center, the center will be paid the amount (on a per visit basis) equal to the amount paid in the previous center fiscal year with no increase by the percentage increase on the Medicare Economic Index (MEI) for primary care services, but adjusted to take into account any increase (or decrease) in the scope of services furnished by the center.

Alternative Prospective Payment System

Beginning with the Federally Qualified Health Center's fiscal year 2003 (FY03), qualifying centers may agree to have their payment rates set using an alternative prospective payment methodology outlined below. The alternative payment methodology agreement between the State and the Federally Qualified Heath Center results in payment to the FQHC of an amount at least equal to the Prospective Payment System payment rate. The State annually evaluates the Medicare Economic Index for primary care services to insure the alternative rate is at least equal to or greater than the PPS rate.

Base rates are calculated prospectively on a per visit basis equal to 100 percent of the inflated average, as explained below, of the allowable and reasonable costs of services furnished during the center's fiscal years 1999 and 2000. The base year costs for FY99 are inflated using the number set out in the first quarter 1999 publication of Global Insight's *Health Care Cost Review,* Skilled Nursing Facility Total Market Basket, inflated to 2002.

The center's allowable and reasonable costs for fiscal year 2000 are inflated by the number set out in the first quarter 2000 publication of Global Insight's *Health Care Cost Review,* Skilled Nursing Facility Total Market Basket, inflated to 2002. The cost per visit is then adjusted for any increase or decrease in the scope of services, based on documentation supplied by the center to justify such an adjustment. For each subsequent fiscal year, the payment rate is increased using the first quarter publication of Global Insight's *Health Care Cost Review,* Skilled Nursing Facility Total Market Basket, then adjusted for any increase or decrease in the scope of services. At least every four years, the department will change the base year to reflect more current cost data for establishing rates. For the state fiscal years 2016 and 2017, if the center's base year is not changing, then the center's payment rate is not increased using the first quarter publication of Global Insight's *Health Care Cost Review,* Skilled Nursing facility Total market Basket, but is adjusted for any increase or decrease in the scope of services.

Prescription drugs and hospital deliveries are excluded from this payment system because they are subject to different methodologies per state regulation.

If the rate established using the alternative prospective payment methodology does not allow reasonable access to quality patient care provided by an efficiently and economically managed facility, the center might apply to the deputy commissioner for consideration of exceptional relief from the rate-setting methodology. The application must include the estimated amount necessary to allow reasonable access to quality care, reasons for the relief requested, management actions taken to respond to the situation, corresponding audited financial statements, descriptions of efforts to offset the deficiencies, an analysis of community needs for the services and how Medicaid patients will lose access available to the general public in the same geographic location without this relief, and any other information requested by the deputy commissioner to evaluate the request.

Methods and Standards for

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The alternative payment methodology agreement between the State and the federally Qualified Health Center will result in payment to the FQHC of an amount that is equal to the Prospective Payment System payment rate. The State will annually evaluate the alternative payment rate to ensure that the alternative rate is at least equal to or greater than the PPS rate and that it does not exceed the payment limit se under 42 CFR 447.300 through 447.371.

Initial payments for FQHCs becoming qualified after State FY00 are established by computing a state-wide weighted average payment to other centers or by cost reporting methods if a minimum of six months of cost data for years 1999 and 2000 is submitted. For each subsequent year, the center will be paid the rate it was entitled to the previous clinic fiscal year plus the percentage increase in the Skilled Nursing Facility Total Market Basket and adjusted for increases or decreases in the scope of service furnished by the Center during that center's fiscal year. For state fiscal years 2016 and 2017, if it is a center's subsequent year, the center will be paid the rate it was entitled to the previous fiscal year with no percentage increase in the Skilled Nursing Facility Total market Basket, but adjusted for increases or decreases in the scope of services furnished by the center during that center's fiscal year.

Home Health Services

Payment is made at 80 percent of billed charges.

Hospice Care Services

Payment is set and adjusted according to the yearly releases from the Centers for Medicare & Medicaid Services (CMS). Alaska's Medicaid program makes adjustments to the rates by the start of the CY (January 1st) immediately after the release of the updated rates by CMS, and these rates are retroactive to the effective date of the CMS material released (usually, October 1st of each year).

Laboratory Services

Payment for laboratory services provided by independent laboratories, physicians in private practice, and hospital laboratories acting as independent laboratories is made at the lesser of billed charges or the Medicare fee schedule. The State Medicaid program recognizes the Medicare fee schedule in place as of June 1st for the annual update of these rates that occurs at the beginning of the next SFY (on July 1st). Unlisted procedures are paid at 80 percent of the amount billed to the general public.

Mammograms

Payment is made at the lesser of billed charges or the Resource Based Relative Value Scale methodology used for physicians.

Medical Supplies and Prosthetic Devices

Payment for durable medical equipment and supplies and prosthetic devices is made at lesser of amount billed the general public or the state maximum allowable. Payment for unusual or custom equipment is authorized on a case-by-case basis and may not exceed the authorized amount.

Except as otherwise noted in the plan, state developed rates are the same for both public and private providers of medical supplies and prosthetic devices. The agency's rates for medical supplies and prosthetic devices were updated on 03/05/2010 and are effective for services rendered on or after 01/01/2010. The fee schedule and any annual/periodic adjustments to the fee schedule and its effective dates are published at http://medicaidalaska.com/providers/FeeSchedule.asp.

Methods and Standards for Establishing
Payment Rates: Other Types of Care

Mental Health Clinic Services

Mental health clinic services provided by a community mental health clinic, state operated mental health clinic, or mental health physician clinic (which is a group of psychiatrists or other mental health professionals working under the supervision of a psychiatrist) are reimbursed at the lesser of the amount billed the general public or the state maximum allowable. Community mental health clinics bill the Division of Behavioral Health under a separate reimbursement schedule for performing pre-admission screening and annual resident reviews (PASARR) of mentally ill persons seeking admission to or residing in long-term care facilities. The State assures that the requirements of 42 CFR 447.321 regarding upper limits of payment will be met. Except as otherwise noted in the plan, state developed fee schedules rates are the same for both governmental and private providers of mental health clinic services. The agency's fee schedule was updated 12/26/2008 and is published in the Departments' Community Behavioral Health Clinic billing manual dated 6/29/12 available at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

Mental Health Rehabilitation Services

Mental health rehabilitation services are reimbursed at the lesser of the amount billed the general public or the state maximum allowable. Except as otherwise noted in the plan state developed fee schedule rates are the same for both governmental and private providers of mental health rehabilitation services. The agency's fee schedule was updated 12/26/08 and is published in the Department's Community Behavioral Health Clinic billing manual dated 6/29/2012 available at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

Nurse-Midwife Services

Payment is made at the lesser of billed charges, 85% of the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. Laboratory services are reimbursed at the lesser of the amount billed the general public or at the Medicare fee schedule. Drugs are covered at 95 percent of the AWP but without a dispensing fee. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of nurse-midwife services. The fee schedule was last updated, to be effective for services on or after 7/1/2016 and is available at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

Methods and Standards for Establishing Payment Rates: Other Types of Care

Nutrition Services

Payment to a registered dietitian is limited to the lesser of the amount billed the general public or a maximum of $50 for an initial assessment, counseling, or evaluation; and $35 for each subsequent visit.

Outpatient Hospital Services

Rate setting principles and methods for Outpatient Hospital Services are contained in Alaska Statutes 47.07.070 - 47.07.900 and administrative regulations in Alaska Administrative Code 7 AAC 43. The Department of Health and Social Services uses the following data sources for setting rates of payment:

- When rebasing occurs, the Medicare Cost Report for the facility's fiscal year ending 12 months before the beginning of the year that is rebased (base year).
- Budgeted capital costs, submitted by the facility and reviewed and adjusted by the Department as appropriate for the rate year on capital projects or acquisitions which are placed in service after the base year and before the end of the rate year and for which an approved Certificate of Need has been obtained.
- Year-end reports that contain historical financial and statistical information submitted by facilities for past rate setting years.
- Utilization and payment history report (commonly known as the MR-0-14) provided by the Division of Medical Assistance.

Allowable costs are documented costs that are ordinary and necessary in the delivery of a cost effective service. Allowable costs are those that directly relate to Title XIX program recipients. Costs would include those necessary to conform to state and federal laws, regulations, and quality and safety standards.

Most of the elements of Medicaid allowable costs are defined in Medicare and reported, subject to audit, on the Medicare Cost Report. The following items are possible allowable and unallowable cost adjustments from financial statement classifications to Medicaid classifications that may be reflected either within the Medicare Cost Report or elsewhere in the Medicaid cost finding process.

1) physician compensation costs and related charges associated with providing care to patients are not allowable for purposes of calculating a prospective payment rate.

2) medical services which a facility or unit of a facility is not licensed to provide are not included as an allowable cost.

3) costs not authorized by a certificate of need when a certificate of need is required are not included as an allowable cost.

4) management fees or home office costs which are not reasonably attributable to the management of the facility are not allowable. Home office costs may not exceed those reported in the most recently Medicare audited Home Office Cost Report.

5) return on investment is not an allowable cost for any facility.

6) advertising cost is allowable only to the extent that the advertising is directly related to patient care. The reasonable cost of the following types of advertising and marketing is allowable:
   - announcing the opening of or change of name of a facility.
   - recruiting for personnel.
   - advertising for the procurement or sale of items.
   - obtaining bids for construction or renovation.
   - advertising for a bond issue.
   - informational listing of the provider in a telephone directory.
   - listing a facility's hours of operation.
   - advertising specifically required as a part of a facility's accreditation process.
7) advocacy and lobbying expenses, along with any costs related to these activities, are not allowable.
8) costs for facility-initiated court or administrative proceedings are non-allowable except when the facility prevails on the issue and the judgment doesn't include an award of fees and costs. Any allowable costs are limited to expenses incurred in the base year.

Allowable patient related costs include wages, salaries, and employee benefits, purchased services; supplies; utilities, depreciation, rentals, leases; taxes, excluding local, state and federal income taxes; and interest expense. Facilities may claim a maximum of 75% of dues, meetings, conference fees, and memberships in trade organizations and associations. A facility must reduce operating costs by the cost of all activities not directly related to health care. Other specific non-allowed costs are bad debts, charity, contractual adjustments and discounts taken by payers. When regulatory changes in allowable costs become effective after the last adjustment for inflation, base year costs and rate calculations may be adjusted and new rates applied to claims with dates of service after the effective date for such regulatory changes.

Prospective payment rates for outpatient hospital services are a percentage of charges except outpatient clinical laboratory services and provider based clinic services. Except as stated in this Subsection**,** the prospective payment rate for outpatient clinical laboratory services will be a per-procedure rate based on reasonable costs as determined by the Medicare fee schedule.

The prospective percentage of charges payment rate for acute hospital outpatient services is determined by applying the outpatient cost to charge ratio for each outpatient cost center from the Medicare Cost Report to the cost center's Medicaid outpatient charges. Laboratory and clinic cost centers are not included in the calculation. The sum of the Medicaid outpatient costs for all outpatient cost centers will then be divided by total Medicaid outpatient charges. The resulting cost to charge percentage, not to exceed 100 percent, will be the prospective outpatient payment rate effective for the fiscal year. Facilities choosing reimbursement under the Optional Prospective Payment Rate Methodology for Small Facilities described in Attachment 4.19A will have their outpatient clinical laboratory services reimbursed at their prospective outpatient percentage of charges payment rate for the term of their agreement. Rebasing will occur for all facilities no less than every four years.

Facilities may choose to be reimbursed under an Optional Prospective Payment Rate Methodology for Small Facilities. A small acute care hospital facility is defined as one that had 4,000 or fewer total inpatient hospital days as an acute care, specialty, or psychiatric hospital or at a combined hospital-nursing facility during the facility's fiscal year that ended 12 months before the beginning of its prospective payment rate year.

A small acute care hospital may elect a new four-year rate agreement if the facility becomes a combined acute care hospital-nursing facility and meets the qualifications described in this section. The facility may choose this option within 30 days after the two facilities combine. The outpatient percentage rate is calculated as the statewide average of the outpatient payment rates in effect for all qualified acute care hospital small facilities as of the date the facilities combine.

For a new facility, the outpatient prospective payment rate percentage is established at the statewide weighted average outpatient payment percentages of acute care and specialty hospitals, in accordance with this section for the most recent 12 months of permanent rates. The outpatient percentages are the statewide weighted average using the base year's outpatient charges. To determine this weighted average, Medicaid charges for the most recent 12 months from each facility are multiplied by the facility's respective rate to get the payment. The sum of facilities' payments is then divided by the sum of their charges to calculate a weighted average outpatient payment percentage.

Method and Standards for

Establishing Payment

Personal Care Services

Services are reimbursed at the lesser of the amount billed the general public or the state maximum allowable.

Except as otherwise noted in the plan, payment for these services is based on state developed fee schedule rates, which are the same for both governmental and private providers of personal care services. The agency's rate for personal care services were updated on 2/01/2012 and are effective for services rendered on or after 07/01/12. The fee schedule and any annual/periodic adjustments to the fee schedule and its effective dates are included in the fee schedule for personal care services published at http://dhss.alaska.gov/dsds/Pages/info/costsurvey.aspx

Physical and Occupational Therapy Services

Payment is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for the physicians, the provider's lowest charge, or the maximum allowable for procedures that do not have an established RVU.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of physical and occupational therapy services. The fee schedule was last updated, to be effective for services on or after 7/1/2016 and is available at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

Physician Assistants

Payment is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the maximum allowable for procedures that do not have an established RVU.

Payment rates are set using the Medicare Physician RBRVS payment rates and Alaska's state-specific conversion factor and inflation adjustments. The Medicare Physician RBRVS payment rates are published in the federal register as described under the Physician reimbursement section of this attachment (4.19B). Alaska's state-specific conversion factor and inflation adjustments are published in the Alaska Administrative Code. Changes to the Medicaid rates will only occur when Medicare updates the RBRVS payment rates each year and the department incorporates those changes with its Alaska-specific conversion factor and inflation adjustments the following July 1.

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Physician Services:

Payment is made at the lesser of billed charges, the Resource Based Relative Value Scale (RBRVS) methodology, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established Relative Value Unit (RVU). The Resource Based Relative Value Scale methodology is that described in 42 CFR 414 except that increases and reductions to the average payment made for an individual procedure billed at least ten times during the previous fiscal year will be phased in until the year 2000. The relative value units used are the most current version published in the Federal register. Non-routine office supplies are reimbursed at the lesser of billed charges or the state maximum allowable.

Surgical reimbursement is in accordance with the Resource Based Value Scale methodology except that multiple surgeries performed on the same day are reimbursed at 100 percent for each additional surgery; bilateral surgeries are reimbursed at 150 percent of the RBRVS rate; co-surgeons are reimbursed by increasing the RBRVS rate by 25 percent and splitting the payment between the two surgeons; and supplies associated with surgical procedures performed in a physician's office are reimbursed at the lesser of billed charges or the state maximum allowable. Payment is made to surgical assistants at the lesser of billed charges or 25 percent of the Resource Based Relative Value Scale methodology.

Payment to physicians for in-office laboratory services are reimbursed at the lesser of the amount billed the general public or the Medicare fee schedule.

Payment is made to the independently enrolled hospital-based physician for certain services at the lesser of the amount billed the general public or 100 percent of the Resource Based Relative Value Scale methodology.

Anesthesia services are reimbursed using the base units and time units and a state determined conversion factor.

State developed fee schedule rates are the same for both public and private providers. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. The fee schedule was last updated, to be effective for services on or after 7/1/2016 and is available at:

http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

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Podiatry Services

Payment is at the lesser of billed charges, the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. State developed fee schedule rates are the same for both public and private providers. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. The fee schedule was last updated, to be effective for services on or after 7/1/2016, and is available at: http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

Prescribed Drugs

(a) Reimbursement will be made to the provider for reasonable and necessary postage or freight costs incurred in the delivery of the prescription from the dispensing pharmacy to a recipient in a rural area. Cross-town postage or delivery charges are not covered. Handling charges are included in the dispensing fee (below) and not directly reimbursed.

(b) The payment for drugs for which the Centers for Medicare and Medicaid has established a specific upper limit amount will be the lowest of the amount billed, estimated acquisition cost, state maximum allowable cost or the federal upper limit plus the dispensing fee.

(c) The payment for drugs for a covered entity described in U.S.C. 256b that indicates it will use covered outpatient drugs purchased through the 340B drug pricing program to bill to Medicaid will be the lower of the submitted actual acquisition cost, the state maximum allowable cost, the federal upper limit, or the estimated acquisition cost plus the dispensing fee.

(d) The payment for drugs for a facility purchasing drugs through the Federal Supply Schedule or drug pricing program under 38 U.S.C. 1826, 42 U.S.C. 256b, or 42 U.S.C. 1396-8, other than the 340B drug pricing program, will be the lower of the billed amount, the wholesale acquisition cost minus 15 percent, the state maximum allowable cost, or the federal upper limit plus the dispensing fee.

(e) The payment for drugs other than those of (b) through (d) above, and for brand names of multiple source drugs specified by the prescriber in accordance with 42 C.F.R. 447.512 will be the assigned dispensing fee plus the estimated acquisition cost of that drug, which is the wholesale acquisition cost published by First Data Bank as updated weekly plus 1 percent of that amount, the payment will not exceed the lower of the estimated acquisition cost plus the dispensing fee or the provider's lowest charge.

(f) The estimated acquisition cost is the wholesale acquisition cost plus 1 percent.

(g) The payment for compounding prescriptions will be the sum of the costs of each of the ingredients as established under (b) through (e) (above), plus the dispensing fee to reimburse no more than the provider's lowest charge.

(h) Effective 7/1/2014 the department will use the National Average Drug Acquisition Cost (NADAC), as calculated and supplied by the Centers for Medicare and Medicaid Services, as the state maximum allowable cost for both brand and generic drugs.

(i) Wholesale acquisition cost with respect to a drug or biological, means the manufacturer's list price for the drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug or biological pricing data.

(j) Practitioner administered drugs are reimbursed at the lower of the billed amount or Wholesale Acquisition Cost plus 1 percent without a dispensing fee.

(k) The dispensing fee is based on the results of surveys of in-state pharmacies' cost of dispensing prescriptions. For each pharmacy, the dispensing fee will be determined using the following schedule:

(1) for a pharmacy located on the road system, the dispensing fee is $13.36, to be paid no more than once every 22 days per individual medication strength;

(2) for a pharmacy not located on the road system, the dispensing fee is $21.28, to be paid no more than once every 22 days per individual medication strength; and

(3) for a mediset pharmacy the dispensing fee is $16.58, to be paid no more than once every 14 days per individual medication strength.

(4) The dispensing fee for an out-of-state pharmacy is $10.76, to be paid no more than once every 22 days per individual medication strength.

(5) A covered outpatient drug dispensed by a dispensing provider will be reimbursed for the drug without a dispensing fee.

(6) In this section,

i. "pharmacy located on the road system" means a pharmacy in this state and is connected to Anchorage by road;

ii. "pharmacy not located on the road system" means a pharmacy located in this state and is not connected to Anchorage by road;

iii. "out of state pharmacy" means a pharmacy that is physically located in a state other than this state;

iv. "mediset pharmacy" means a pharmacy dispensing 75% or more of the total annual Medicaid prescription for covered outpatient drugs in prescriber-ordered medisets or unit doses to a recipient living in a congregate living home, a recipient of home and community-based waiver services, a recipient eligible

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for Medicaid under a category set out in 7 AAC 100.002(b) or (d) who is blind or disabled, a recipient who is an adult experiencing a serious mental illness, or a recipient who is a child experiencing a severe emotional disturbance.

(l) A pharmacy may not refuse to fill an interim prescription occurring before the end of the 14 or 22 days as the dispensing fee covers the 14 or 22 days period.

(m) Payment is restricted to drugs supplied by manufacturers who have a signed national agreement or an approved existing agreement under the Medicaid Drug Rebate program of Sec 1902(a)(54) and Sec. 1927 of the Act, and the only drugs supplied by such manufacturers that are not reimbursed are those excluded under Attached Sheet to Attachment 3.1A.

(n) The department will pay the lesser of the pharmacy's assigned dispensing fee, as specified in section (k) or the submitted dispensing fee.

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Private Duty Nursing for Children Under 21

Payment for private nursing is the lesser of amount billed the general public or $80 per hour for registered nurse services and $75 per hour for licensed practical nurse services. Hours must be justified in a physician-approved plan of care, must be less than 24 hours per day, and cannot, when added to the other Medicaid services used by the child, exceed the cost of institutional care.

Radiology Services

Payment for radiology services provided by independent radiology facilities is made at the lesser of billed charges, the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. This maximum allowable payment is a single rate per procedure code. The agency's rates for radiology services were updated on July 1, 2012 and are effective for dates of service after on or after that date. The state assures that the requirement of 42 CFR 447.325 regarding upper limits of payment will be met.

Renal Dialysis Physician Clinics

Payment for renal dialysis clinic services is a composite, per-treatment rate of $1,000 for hemodialysis and $500 for peritoneal dialysis. This maximum allowable payment is a single rate per procedure. The rates established for renal dialysis clinic services are all inclusive, except that erythrocyte-stimulating agents and parenteral iron replacement products are separately reimbursable under existing prescribed drug payment methodology. These rates are effective January 1, 2013. To ensure that payment rates are economic and efficient, the State will calculate a clinic upper payment limit as described at 42 CFR 447.321.

Inpatient Psychiatric Services for Individuals for Children Under 21

Payment to a non-profit facility accredited by JCAHO for residential treatment of emotionally disturbed children is an all-inclusive daily rate established by the department, effective July 1, 2010. The department will pay for therapeutically appropriate, medically necessary diagnostic and treatment services for a child experiencing a severe emotional disturbance, including the following services: individual psychotherapy; group psychotherapy; family psychotherapy; group skill development services; individual skill development services; family skill development services; pharmacologic management and medication administration; crisis intervention; and intake assessment.

Respiratory Therapy Services

Payment for respiratory therapy services is made at the lesser of the amount billed the general public or the state maximum allowable. This maximum allowable payment is a single rate per procedure code. The agency's rates for respiratory therapy services were updated on July 1, 2012 and are effective for dates of service after on or after that date.

Rural Health Clinic Services

Payment for Rural Health Clinic Services conforms to section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000.

Prospective Payment System

All Rural Health Clinic Services are reimbursed on a prospective payment system beginning with Fiscal Year 2001 with respect to services furnished on or after January 1, 2001 and each succeeding year.

Payment rates are set prospectively using the total of the clinic's reasonable costs for the clinic's fiscal years 1999 and 2000. These costs are divided by the average number of visits for the two-year period to arrive at a cost per visit. The cost per visit is adjusted to take into account any increase or decrease in the scope of services. The cost per visit is the prospective rate for calendar year 2001. Beginning in FY 2002, and for each clinic fiscal year thereafter, each clinic will be paid the amount (on a per visit basis) equal to the amount paid in the previous clinic fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the clinic. The clinic must supply documentation to justify scope of service adjustments.

For newly qualified RHCs after State fiscal year 2000, initial payments are established either by reference to payments to other clinics in the same or adjacent areas with similar caseload, or in the absence of other clinics, by cost reporting methods. After the initial year, payment is set using the MEI methods used for other clinics, and adjustments for increases or decreases in the scope of service furnished by the clinic during that fiscal year.

Alternative Prospective Payment System

Beginning with the Rural Health Clinic's fiscal year 2003 (FY03), qualifying clinics may agree to have their payment rates set using the alternative prospective payment system outlined below. The alternative payment methodology agreement between the State and the Rural Health Clinic (RHC) results in payment to the RHC of an amount at least equal to the Prospective Payment System (PPS) payment rate. The state annually evaluates the Medicare Economic Index for primary care services to insure the alternative rate is at least equal to or greater than the PPS rate.

Base rates are calculated prospectively on a per visit basis equal to 100 percent of the inflated average, as explained below, of the allowable and reasonable costs of services furnished during the center's fiscal years 1999 and 2000. The base year costs for fiscal year 1999 are inflated using the number set out in the first quarter 1999 publication of Global Insight's *Health Care Cost Review,* Skilled Nursing Facility Total Market Basket inflated to 2002.

The clinic's allowable and reasonable costs for fiscal year 2000 will be inflated by the number set out in the first quarter 2000 publication of Global Insight's *Health Care Cost Review,* Skilled Nursing Facility Total Market Basket inflated to 2002. The cost per visit is then adjusted for any increase or decrease in the scope of services, based on documentation supplied by the clinic to justify such an adjustment. For each subsequent fiscal year, the payment rate is increased using the first quarter publication of Global Insight's *Health Care Cost Review,* Skilled Nursing Facility Total Market Basket and then adjusted for any increase or decrease in the scope of services. At least every four years, the department will change the base year to reflect more current cost data for establishing rates.

Prescription drugs and hospital deliveries are excluded from this payment system because they are subject to different methodologies per state regulation. Prescription drugs are subject to drug coverage limitations in 7 AAC 43.490 and are reimbursed in accordance with 7 AAC 43.591. Hospital deliveries are reimbursed in accordance with 7 AAC 43.107(b).

If the rate established using the alternative prospective payment methodology does not allow reasonable access to quality patient care provided by an efficiently and economically managed facility, the clinic may apply to the deputy commissioner for consideration of exceptional relief from the rate-setting methodology. The application must include the estimated amount necessary to allow reasonable access to quality care, reasons for the relief requested, management actions taken to respond to the situation, corresponding audited financial statements, descriptions of efforts to offset the deficiencies, an analysis of community needs for the services and how

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The alternative payment methodology agreement between the State and the Rural Health Clinic will result in payment to the Rural Health Clinic of an amount that is at least equal to the Prospective Payment System payment rate. The State will annually evaluate the alternative payment rate to ensure that the alternative rate is at least equal to or greater than the PPS rate and that it does not exceed the payment limit set under 42 CFR 447.300 through 447.371.

Initial payments for Rural Health Clinics becoming qualified after State FY00 are established by computing a state-wide weighted average payment to other clinics or by cost reporting methods if a minimum of six months of cost data for years 1999 and 2000 is submitted. For each subsequent year, the clinic will be paid the rate it was entitled to the previous clinic fiscal year increased by the percentage increase in the Skilled Nursing Facility Total Market Basket and adjusted for increases or decreases in the scope of service furnished by the clinic during that clinic's fiscal year.

Description of Service Limitations

School-Based Rehabilitative Services

The division will reimburse an enrolled school district for those procedures identified in the United States Department of Health and Human Services, Centers for Medicare and Medicaid's (CMS) Healthcare Common Procedure Coding System (HCPCS) 2003 that are provided as a rehabilitative service. Payment is made at 85% of the rate identified in the State's fee schedule for all providers of physical therapy, occupational therapy, speech-language therapy, and hearing services, whether school-based or community-based. The maximum allowable rates for all services are calculated using the Resource Based Relative Value Scale (RBRVS) methodology described in 42 CFR 414. The relative value units used are the most current version published in the Federal Register.

Speech, Hearing and Language Services

The department will pay for speech pathology/audiology services if they are identified in the *CPT Fee Schedule for Speech Pathologist* table and *HCPC Fee Schedule for Speech Pathologists* table.

Payment for speech-language pathology services provided by a speech pathologist or outpatient speech therapy center is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. Payment for hearing services provided by an audiologist is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. Payment to a hearing aid supplier is made at the lesser of billed charges or the state maximum allowable.

Substance Abuse Rehabilitation Services

The following substance abuse rehabilitation services are reimbursed at the lesser of the amount billed the general public or the state maximum allowable:

(a) assessment and diagnosis services;
(b) outpatient services, including individual, group, and family counseling; care coordination; and rehabilitation treatment services;
(c) intensive outpatient services;
(d) intermediate services; and
(e) related medical services, including medical evaluation for admission into methadone treatment, intake physical for nonmethadone recipient, methadone treatment plan review, medication management, medication dispensing, and urinalysis and detoxification services.

Targeted Case Management

For care coordination services see Substance Abuse Rehabilitation Services.

For family and client support services see Mental Health Rehabilitation Services.

Payment Methodology for all types of Targeted Case Management

Payment for Infant Learning Program Targeted Case management will be based on a monthly encounter rate. The payment rate is calculated prospectively and is based on the following:

Rate Computation Methodology

The prospective rate for payment of case management services is computed annually using the following formula. The data for this computation will be taken from the base year, that is the first full year before providers billed for Targeted Case Management services under this section, and will be inflated forward using an inflation index approved by the Department. For fiscal years 2016 and 2017, the data for this computation taken from the base year will not be inflated forward.

Compute the	Annual Case Manager salary and fringe benefits
Plus	Other anticipated operating cost including travel, supplies, telephone, and occupancy cost
Plus	Direct supervisory cost
Plus	Average indirect administrative cost of provider organization
Divided by	TOTAL STATEWIDE NUMBER OF CASE MANAGERS
Equals	TOTAL STATEWIDE ANNUAL COST PER CASE MANAGER
Divided by	12
Equals	MONTHLY STATEWIDE AVERAGE COST PER CASE MANAGER
Divided by	Statewide average number of children served per month
Equals	TOTAL STATEWIDE AVERAGE MONTHLY COST PER CHILD

The total cost per case manager is the sum of the case manager's reasonable salary, direct supervisory cost, indirect administrative costs of the provider organization, and other operating costs such as travel, supplies, occupancy, and telephone. Dividing the statewide average cost per case manager by twelve (12) months yields the average statewide monthly cost per manager. Dividing the statewide monthly cost per case manager by the average monthly number of children served statewide results in the total monthly cost per child. This is the encounter rate to be used by the provider for billing whenever a Medicaid eligible client receives a TCM service during the month. Providers may only bill the encounter rate once per child per month and must keep documentation to verify this practice.

Payment Methodology for Under 21 Targeted Case Management

Rate Determination: The monthly rate for case management services is based on the total average monthly cost per client served by the provider. The monthly rate is limited to the provider's direct service and administrative costs associated with case management service delivery. The rate is computed by taking the provider's monthly case management cost divided by the monthly number of clients that are provided case management services.

The rate is established prospectively. In the first year, the rate is based on estimates of cost and the number of clients to be served. For subsequent years, the rate is based on actual case management costs for previous years. A cost statement is completed at the end of each state fiscal year once the actual costs incurred have been determined.

Payment Methodology: Payment will be made through MMIS. The provider will bill at the full monthly rate for each client provided case management services during that month. An encounter is a case management activity performed on the client's behalf. Each encounter will be documented to support the billing. Encounters include but are not limited to in-person, phone, mail, email, and other means.

Payment Methodology for Tribal Targeted Case Management

"Unit" is defined as a month. A unit consists of at least one documented contact with the individual (or other person acting on behalf of the individual) and any number of documented contacts with other individuals or agencies identified through the case planning process.

Payment for tribal targeted case management will be made using a monthly rate based on the total average monthly cost per case management client served by the provider during the fiscal year ending 12 months before the beginning of the prospective rate year. Direct and related indirect costs that are paid by other Federal programs must be removed from the cost pool. The cost pool must be updated, at a minimum, on an annual basis using a provider cost report. The rate is established on a prospective basis. In the first 3 years, the rate will be based on estimates of cost and the number of clients served. For subsequent years, the rate will be actual monthly case management costs per case management client served by the provider from the fiscal year ending 12 months before the beginning of the prospective rate year. A cost report and audited financial statements must be submitted to the Department at the end of each state fiscal year (at a minimum), and will be used to establish a new rate for the prospective rate year beginning 12 months after the end of the fiscal year.

Transportation Services

Emergency and non-emergency transportation services are paid at the lesser of the amount billed the general public or the state maximum allowable if such a maximum has been established. State developed fee schedule rates are the same for both public and private providers. The agency's fee schedule rates were set as of August 27, 2012 and are effective for services provided on or after that date. All rates are published at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp .

The following types of emergency transportation services for recipients are payable at the lesser of the amount billed the general public or the state maximum allowable, published at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp:

- Ground ambulance service, whether within the same community or outside of it;
- Air ambulance service.

The following types of non-emergency transportation services for recipients and authorized escorts are payable at the amount billed the general public or the state negotiated rate, when applicable:

- Commercial airline service;
- Ferry service;
- Ground transportation.

The State maintains files of negotiated rates.

With the exception of government operated accommodations, meal and lodging costs for recipients and approved escorts are reimbursed at the lesser of the amount billed the general public or the state maximum allowable per day, which is the government rate established for all publicly funded travel-related room and board.

Costs for recipients and approved escorts utilizing government-operated accommodations are reimbursed at the lesser of the amount billed to the general public or the federally negotiated per diem rate.

Prior authorization is required for all non-emergency transportation and all lodging and meal costs for both recipients and escorts.

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Telemedicine Applications

Payment for services delivered via telemedicine is made according to the Medicaid payment methodology for the service and provider type. Reimbursement is made for a telemedicine application if the service is:

1. An initial visit;
2. A follow-up visit;
3. A consultation made to confirm a diagnosis;
4. A diagnosis, therapeutic referrals/orders, or interpretive service;
5. A psychiatric or substance abuse assessment; or
6. Psychotherapy or pharmacological management services on an individual recipient basis.

Separate reimbursement is not made for the use of technological equipment and systems associated with a telemedicine application to render the service.

Vision Care Services

Reimbursement is made at the lesser of billed charges, the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that to not have an established RVU. The state awards a competitive-bid contract for eyeglasses.

Optometry Services

Payment is made at the lesser of billed charges, the Resource Based Relative Value Scale (RBRVS) methodology used for physicians, or the provider's lowest charge. State developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of 7/1/2016 and are effective for dates of services on or after that date. The fee schedule and its effective dates are published at http//manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp.

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Tobacco Cessation

Pharmacies providing prescribed tobacco cessation medication therapy management through a qualified pharmacist to a recipient with a prescription will be paid the lesser of billed charges or the tobacco cessation counseling fee of $16.00.

Vaccine Reimbursement

For Medicaid eligible individuals through 18 years of age –

1) Administration of Preventive Vaccines is only reimbursed via an Administration fee to participating/enrolled Alaska VFC providers under the Vaccines for Children (VFC) program. Information regarding the VFC program is found on page 66(b) of Alaska's Medicaid State plan.

For Medicaid eligible individuals aged 19 and over –

1) Qualified, enrolled, licensed, Medicaid providers in Alaska practicing within their scope of practice will be reimbursed an administration fee as follows:
2)
   a) Physicians will be reimbursed the lesser of billed charges or 100% of the applicable physician CPT code and/or the applicable vaccine CPT code as of the effective date of October 1, 2009, and subsequently modified by any annual/periodic adjustments to the fee schedule.

   b) Nurse practitioners and physicians assistants will be reimbursed the lesser of billed charges or 85% of the applicable physician CPT code and/or the applicable vaccine CPT code as of the effective date of October 1, 2009, and subsequently modified by any annual/periodic adjustments to the fee schedule.

   c) Pharmacists will be reimbursed the lesser of the estimated acquisition cost or billed charges plus an administration fee of $17.46. Qualified pharmacists as authorized under "Other Licensed Practitioners" at 42 CFR 440.60 are not eligible to receive a dispensing fee for vaccines when an administration fee is paid.

   State developed fee schedule rates are the same for both public and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule and its effective dates are published at http://www.medicaidalaska.com/providers/Billing.shtml. The fee schedule was last updated on 02/02/12, to be effective for services on or after 12/01/11.

REIMBURSEMENT FOR INDIAN HEALTH SERVICE
AND TRIBAL HEALTH FACILITIES
(Continued)

Other Services

Dental Services

Effective January 1, 2008 Tribal Dental services are reimbursed at the most current outpatient per visit rate published in the federal register by the Indian Health Service. For the calendar 2007 transition year Tribal Dental services will be reimbursed at the 2007 outpatient per visit rate adjusted by the ndian Health Service with the previously excluded dental costs and workload statistics.

REIMBURSEMENT FOR INDIAN HEALTH SERVICE
AND TRIBAL HEALTH FACILITIES
(Continued)

Other Services-Cont'd

Behavioral Health Services
Payment for Behavioral Health Services is made at the most current outpatient per visit rate published in the federal register by the Indian Health Service.

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

The Medicaid agency will adjust payments for provider health care-acquired conditions and other provider preventable conditions as follows: after post payment review of the medical record by a QIO, the Medicaid agency will reduce payment by recouping funds that were paid for dates of service that were a direct result of a provider preventable condition.

In compliance with 42 CFR 447.26(c), the Medicaid Agency provides:

1) That no reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.
2) That reductions in provider payment may be limited to the extent that the following apply:
   i. The identified provider preventable conditions would otherwise result in an increase in payment.
   ii. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider preventable conditions.
3) Assurance that non-payment for provider preventable conditions does not prevent access to services for Medicaid beneficiaries

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19 (A)

___Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19 _B___

__√_ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

____ Additional Other Provider-Preventable Conditions identified below *(please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example – 4.19(d) nursing facility services, 4.19(b) physician services)* of the plan: